STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G495	A. BUILDING 00 B. WING	09/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REM-INDIANA INC	6338 GRAHAM RD INDIANAPOLIS, IN46220

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W0000	This visit was for the annual recertification and state licensure survey. Survey dates: 9/6/11, 9/7/11, 9/8/11, 9/9/11, 9/13/11 and 9/16/11. Facility Number: 001009 Provider Number: 15G495 AIMS Number: 100244970 Surveyor: Keith Briner, Medical Surveyor III These deficiencies also reflect state findings in accordance with 431 IAC 1.1. Quality Review completed 9/23/11 by Chris Greeney, ICF-ID Surveyor Supervisor and Ruth Shackelford, Medical Surveyor III.	W0000		
W0149	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observation, interview and record review for 1 of 4 sampled clients (client #4), the facility failed to implement its policy and procedures regarding the potential neglect of client #4. Findings include: Observations were conducted at the group home on 9/7/11 from 6:00 AM through	W0149	The Program Directtor completted a review ofl all consumers, including Clientt#4, diett orders and MARs tto review diettary need/resttrictttons as well as ifl any consumers had any allergies. All sttafl will receive rettraining on all consumers' diett orders and allergy listts Training will include tthe need tto ensure tthatt substtttutte flood ittems are oflered ifl somettthing a consumer is allergic tto is oflered on tthe menu	10/16/2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	8:00 AM. Client #4 was observed in the group home throughout the observation period. At 7:20 AM client #4 participated in family style dining with his peers for the morning meal. Client #4 was offered orange slices as part of his menu meal. Client #4 placed the orange slices on his plate and consumed his portion of french toast which was also located on the plate with the orange slices. Client #4 was not observed eating the orange slices. PD #1 (Program Director), HM #1 (Home Manager), staff #1, staff #2 and/or staff #3 were not observed prompting client #4 to remove the orange slices from his plate, or offer an alternative food item. The facility's posted Week 4, Summer menu was reviewed on 9/7/11 at 6:20 AM. The menu included but was not limited to 1 sliced orange for the breakfast meal on 9/7/11. Client #4's record was reviewed on 9/8/11 at 12:40 PM. Client #4's ISP (Individual Support Plan) dated 8/1/11 indicated his current diagnosis included but was not limited to: down's syndrome and severe intellectual disability. Client #4's ISP indicated he was not independent with meal time choices and/or behavior and needed support in order to maintain healthy nutrition. Client #4's Nutritional Review Document dated 8/1/11 indicated		For flour weeks tthe Home Manager and/or Program Directtor will complette mealttme observattons att leastt ttwo ttmes per week tto observe ifl sttafl are flollowing diett orders and nott oflering consumers ittems tthey are known tto have an allergic reactton tto and make sure sttafl are oflering appropriatte substttttuttes as needed. Ongoing tthe Home Manager and/or Program Directtor will complette mealttme observattons att leastt one ttme per week tto observe ifl sttafl are flollowing diett orders and nott oflering consumers ittems tthey are known tto have an allergic reactton tto and make sure sttafl are oflering appropriatte substttttuttes as needed Responsible Partty Directt Supportt sttafl Home Manager, Program Directtor	

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	client #4 had a food allergy to strawberries and oranges/orange juice. Interview with HM #1 on 9/8/11 at 1:45 PM indicated client #4 was served oranges as part of his morning meal on 9/7/11. HM #1 indicated client #4 did have a food allergy to oranges and had the potential for an allergic reaction. HM #1 indicated client #4 is not able to identify the risks associated with consuming oranges. Interview with PD #1 on 9/8/11 at 1:54 PM indicated client #4 should not be offered food items that he is allergic to. The facility's policy and procedures were reviewed on 9/9/11 at 4:00 PM. The facility's 6/07 policy and procedure entitled Quality Risk Management indicated the following, "A service delivery site that compromises the health and safety of an individual while the individual is receiving services form the following causes: Event with the potential for causing significant harm or injury...." 1.1-3-2(a)			

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W0153	The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview for 1 of 8 allegations of abuse/mistreatment and/or injury of unknown origin reviewed, the facility failed to report an incident of client to client aggression for clients #6 and #8 within 24 hours to the administrator, and to the Division of Disability, Aging and Rehabilitative Services (DDARS)/BDDS (Bureau of Developmental Disabilities Services) per 431 IAC 1.1-3-1 (b) (5) and to Adult Protective Services (APS) per IC 12-10-3 . Findings include: The facility's incident reports, reportable incident reports and/or investigations were reviewed on 9/6/11 at 4:20 PM. The review indicted the following: -BDDS report submitted on 3/16/11 indicated on 3/14/11 at 7:00 PM client #6 and client #8 were involved in a physical altercation. Interview with administrative staff #1 on 9/7/11 at 1:38 PM indicated all BDDS reportable incidents are supposed to be reported by staff within 24 hours of the incident. Administrative staff #1 indicated incidents of client to client aggression are considered BDDS reportable incidents. 1.1-3-2(a)	W0153	All directt care sttafl working att tthis home will receive rettraining on incidentt reporttng requirementts including whatt incidentts need tto be reportted, designatted ttmeflrames in which incidentts are tto be reportted and tthe procedure flor immediattely nottflying tthe on call supervisor ofl reporttable incidentts The Home Manager will complette a tthorough review ofl consumers records including Daily Supportt records, Medical Administtratton Records, behavior ttracking and narrattve nottes a minimum of 3 ttmes per week flor 2 montths tto ensure tthatt all incidentts tthatt flall under tthe BDDS reporttable guidelines are reportted tto tthe Program Directtor witthin tthe designatted ttmeflrames Afler tthe 2 montth period, tthe HM will complette a tthorough review ofl consumers records including Daily Supportt records, Medical Administtratton Records, behavior ttracking and narrattve nottes a minimum ofl 1ttme per week tto ensure tthatt all incidentts tthatt flall under tthe BDDS reporttable guidelines are reportted tto tthe Program Directtor witthin tthe designatted ttmeflrames For 2 montths tthe Program Directtor	10/16/2011

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			will complette a tthorough review ofl consumers records including Daily Supportt records, Medical Administtratton Records, behavior ttracking and narrattve nottes a minimum ofl 1ttme per week tto ensure tthatt all incidentts tthatt flall under tthe BDDS reporttable guidelines are reportted tto tthe Program Directtor witthin tthe designatted ttmeflrames The Program Directtor will receive rettraining on QMRP responsibilittes including ensuring tthatt documenttatton ofl BDDS reporttable incidentts are reportted tto tthe Administtrattor witthin designatted ttmeflrames and ensuring tthatt resultts ofl any needed investtgattons are being reportted tto tthe administtrattor witthin 5business days ofl tthe incidentt Ongoing tthe Area Directtor will review all BDDS reportts and investtgattons tto ensure tthatt incidentts are being reportted tto tthe administtrattor witthin designatted ttme flrames and tthatt needed investtgattons are reportted tto tthe administtrattor witthin 5 business days ofl tthe incidentt Responsible Partty, Home Manager, Program Directtor, Area Directtor, Qualitty Assurance Specialistt	
W0189	The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. Based on record review and interview for	W0189	Since documenttatton could nott be secured tthatt documentted tthatt Sttafl	10/16/2011

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	4 of 4 sampled clients (#1, #2, #3 and #4) plus 4 additional clients (#5, #6, #7 and #8), the facility failed to ensure a facility staff was retrained in medication administration and to ensure facility staff was trained in regard to medication administration prior to working alone with clients. Findings include: Staff #1's employee file was reviewed on 9/7/11 at 1:40 PM with administrative staff #1. Staff #1's employee file did not indicate the staff had completed and successfully passed Core A and/or Core B medication administration training within the required 120 day timeframe. Staff #1's record indicated a hire date of 11/20/10. Interview with administrative staff #1 on 9/7/11 at 2:00 PM indicated staff #1 was a currently employed by the facility but was on LOA (Leave of Absence) due to personal reasons. Administrative staff #1 indicated staff #1 had been employed with the facility since 11/20/10 and should have received medication administration training during the initial orientation process. Administrative staff #1 indicated all staff working in the group home with the clients are required to successfully complete Core A and Core B curriculum prior to working with the clients alone.		#1 had successflully passed Core A and Core B curriculum when hired, Sttafl#1 received rettraining on Core A and Core B curriculum on 10/4/11. The Home Manager and Program Directtor will receive rettraining on ensuring tthatt all sttafl working in tthe home have been ttrained on tthe Core A and Core B curriculum prior tto working in tthe group home alone witth consumers and prior tto passing any consumers medicattons. Ongoing tthe Home Manager and Program Directtor will work witth Human Resources sttafl tto ensure tthatt all sttafl have successflully passed Core A and Core B curriculum prior tto tthem being allowed tto work in tthe home alone witth consumers and prior tto tthem passing any consumers medicattons. Responsible Partty Home Manager, Program Directtor, Human Resources Sttafl	

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	Administrative staff #1 indicated staff #1 had been working with the clients since her hire date and had worked with the clients alone throughout her time of employment. Interview with HM (Home Manager) #1 on 9/7/11 at 2:45 PM indicated staff #1 should have been trained on Core A and Core B curriculum prior to working in the group home alone with the clients. HM #1 indicated staff #1 had been working with the clients throughout her employment with the facility. Interview with PD #1 (Program Director) #1 on 9/7/11 at 2:50 PM indicated staff #1 should have been trained on Core A and Core B curriculum prior to working in the group home alone with the clients. HM #1 indicated staff #1 had been working with the clients throughout her employment with the facility. PD #1 indicated staff #1 would have to complete the training prior to resuming duties at the group home. 1.1-3-3(a)			
W0218	The comprehensive functional assessment must include sensorimotor development. Based on observation, record review and interview for 1 of 4 sampled clients (client #2), the facility failed to ensure a current	W0218	Clientt#2 has been reflerred tto tthe Rehab Hospittal ofl Indiana An assessmentt will be scheduled att tthe earliestt datte The Program Directtor	10/16/2011

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	and/or accurate SMA (Sensorimotor Assessment) to assessment to meet the client's needs. Findings include: Observations were conducted at the group home on 9/6/11 from 5:00 PM through 6:30 PM and on 9/7/11 from 6:00 AM through 8:00 AM. Client #2 was observed in the group home throughout both observation periods. Client #2 was visually impaired in that he was blind and had no eyesight. On 9/6/11 at 6:00 PM client #2 was prompted by staff to come to the dining room to participate in family style dining. Client #2 was offered a plate, silverware and cup to use for his meal. Client #2 was served spaghetti with sauce, salad, bread and fruit. Client #2 used his fork to scoop the spaghetti from his plate to his mouth. As client #2 used the fork in this manner, the spaghetti would slide off the side of the plate. Client #2 then began utilizing his fingers to hold the spaghetti in position as he used his fork to scoop the food. Client #2 was then offered a bowl to use in order to prevent the food from being pushed off of the plate and client #2 from using his hands. On 9/7/11 at 7:07 AM client #2 was prompted to come to the dining room table to participate in family style dining		will convene tthe IDT flollowing tthe assessmentt tto address tthe recommendattons. The Program Directtor will receive rettraining on assessmentt requirementts tto include tthe need flor a sensorimottor assessmentt Once recommendattons are received flrom tthe assessmentt and tthe IDT has mett tto discuss recommendattons, tthe Program Directtor will develop goals as needed and ttrain sttafl on any recommendattons tto ensure tthatt Clientt#2 receives appropriatte assisttance in becoming more independentt att mealttmes Ongoing tthe Area Directtor will review tthe nextt3 ISPs written by tthe Program Directtor tto ensure tthatt Comprehensive Functtonal Assessmentts are completted prior tto tthe ISP and speciflcally include sensory/mottor developmentt Responsible Partty: Program Directtor, Area Directtor	

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	with his peers. Client #2 was offered a plate, silverware and cup for use during his meal. Client #2 was offered french toast as part of his morning meal. Client #2 used his fork to scoop the french toast from his plate to his mouth. As client #2 used the fork in this manner, the french toast pieces would slide off the side of the plate. Client #2 then began utilizing his fingers to hold the french toast in position as he used his fork to scoop the food. Client #2 was then offered a bowl to use in order to prevent the food from being pushed off of the plate and client #2 from using his hands. Client #2 was not observed using a plate guard, divided plate or other adaptive meal time equipment. Interview with HM (Home Manager) #1 on 9/7/11 at 2:33 PM indicated client #2's visual impairments make it difficult for him to scoop food and keep foods separated on his plate during consumption. HM #1 indicated staff will generally offer him a bowl to use instead of a plate. HM #1 indicated she did not know of any recent SMA or if any adaptive devices had been attempted with client #2. HM #1 indicated client #2 would benefit from an SMA to determine any additional supports that could be used.			

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	Interview with PD (Program Director) #1 on 9/7/11 at 2:40 PM indicated she had also observed client #2 having difficulty using the fork and plate during the observations. PD #1 indicated she did not know of any SMA that had been done on client #2 to determine if a plate guard and/or a divided plate would be appropriate. PD #1 indicated client #2 would benefit from an SMA. Interview with AS (Administrative Staff) #1 on 9/7/11 at 2:44 PM indicated client #2 should have a current SMA to assess his meal time independence. Client #2's record was reviewed on 9/7/11 at 1:23 PM. Client #2's record indicated a SMA on 12/22/10 with no recommendations. Client #2's ISP (Individual Support Plan) dated 10/29/10 indicated mealtime assistance was needed. Client #2's ISP indicated the client was in need of supports during meal time to increase his independence and skills. 1.1-3-4(a)			

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W0259	At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed. Based on record review and interview for 1 of 3 sampled clients (#4), the facility failed to ensure client #4 had a CFA (Comprehensive Functional Assessment) updated annually. Findings include: Client #4's record was reviewed on 9/8/11 at 12:40 PM. Client #4's record indicated a CFA dated 8/1/10. Interview with AS (Administrative Staff) #1 on 9/9/11 at 1:32 PM indicated there were no additional CFA for review for client #4. 1.1-3-4(a)	W0259	The Program Directtor will receive rettraining on tthe need tto ensure tthatt all consumers have currentt Comprehensive Functtonal Assessmentts and tthatt tthese are uttlized in tthe developmentt ofl ttraining objecttves Ongoing tthe PD will ensure tthatt all consumers have currentt ISPs, currentt CFA's and goals and objecttves based on tthe needs assessed in tthe CFA tto assistt tthem in becoming more independentt Ongoing tthe Area Directtor will review tthe nextt3 ISPs written by tthe Program Directtor tto ensure tthatt goals/objecttves are developed ensure consumers are working on ttasks tthatt will allow tthem tto become more independentt Responsible Partty: Program Directtor, Area Directtor	10/16/2011
W0436	The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. Based on observation, interview and record review for 1 of 4 sampled clients (#5), the facility failed to encourage and/or teach the client to use dentures. Findings include:	W0436	A goal will be developed flor Clientt#4 tto encourage him tto wear his denttures. Clientt#4 ISP will be updatted tto reflectt tthe goal tto encourage tthe dentture wearAll sttafl will receive rettraining on Clientt #4 goal tto encourage him tto wear his	10/16/2011

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	Observations were conducted at the group home on 9/6/11 from 5:00 PM through 6:30 PM and on 9/7/11 from 6:00 AM through 8:00 AM. Client #4 was observed in the group home throughout both observation periods. Client #4 was edentulous in regard to his upper teeth. Client #4 was not observed using/wearing upper dentures. PD #1 (Program Director), HM #1 (Home Manager), staff #1, staff #2, staff #3, staff #4 and/or staff #5 were not observed prompting or encouraging client #5 to use his dentures. Interview with HM #1 on 9/9/11 at 11:18 AM indicated client #5 refuses to wear his dentures. HM #1 indicated client #5 should be encouraged and/or trained to use his dentures. Client #5's record review was reviewed on 9/7/11 at 9:40 AM. Client #5's ISP (Individual Support Plan) dated 5/23/11 indicated the use of dentures. Client #5's ISP did not indicate a formal training objective to teach client #5 to use and/or wear his dentures. 1.1-3-7(a)		denttures Once sttafl are ttrained on Client #4 dentture goal, tthe Home Manager and/or Program Directtor will complette acttve ttreattmentt observattons a minimum ofl2 ttmes per week tto ensure tthatt tthe goal is being implementted The Program Directtor will receive rettraining on tthe need tto ensure tthatt goals/objecttves are developed as needed tto ensure consumers are working on ttasks tthatt will allow tthem tto become more independentt Ongoing tthe Area Directtor will review tthe next 3 ISPs written by tthe Program Directtor tto ensure tthatt goals/objecttves are developed ensure consumers are working on ttasks tthatt will allow tthem tto become more independentt Responsible Partty: Home Manager, Program Directtor, Area Directtor	
W0460	Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.			

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	Based on observation, interview and record review for 1 of 4 sampled clients (client #4), the facility failed to follow the client's diet by serving him a food he was allergic to. Findings include: Observations were conducted at the group home on 9/7/11 from 6:00 AM through 8:00 AM. Client #4 was observed in the group home throughout the observation period. At 7:20 AM client #4 participated in family style dining with his peers for the morning meal. Client #4 was offered orange slices as part of his menu meal. Client #4 placed the orange slices on his plate and consumed his portion of french toast which was also located on the plate with the orange slices. Client #4 was not observed eating the orange slices. PD #1 (Program Director), HM #1 (Home Manager), staff #1, staff #2 and/or staff #3 were not observed prompting client #4 to remove the orange slices from his plate, or offer an alternative food item. The facility's posted Week 4, Summer menu was reviewed on 9/7/11 at 6:20 AM. The menu included but was not limited to 1 sliced orange for the breakfast meal on 9/7/11. Client #4's record was reviewed on 9/8/11 at 12:40 PM. Client #4's ISP (Individual Support Plan) dated 8/1/11 indicated his current diagnosis included but was not limited to: down's syndrome and severe intellectual disability. Client #4's ISP indicated he was not independent with meal time choices and/or behavior and needed support in order to maintain healthy nutrition. Client #4's Nutritional Review Document dated 8/1/11 indicated client #4 had a food allergy to strawberries and oranges/orange juice.	W0460	The Program Directtor completted a review ofl all consumers, including Clientt#4, diett orders and MARs tto review diettary need/resttrictttons as well as ifl any consumers had any allergies. All sttafl will receive rettraining on all consumers' diett orders and allergy listts Training will include tthe need tto ensure tthatt substttutte flood ittems are oflered ifl sometthing a consumer is allergic tto is oflered on tthe menu For flour weeks, tthe Home Manager and/or Program Directtor will complette mealttme observattons att leastt ttwo ttmes per week tto observe ifl sttafl are flollowing diett orders and nott oflering consumers ittems tthey are known tto have an allergic reactton tto and make sure sttafl are oflering appropriatte substttttuttes as needed. Ongoing tthe Home Manager and/or Program Directtor will complette mealttme observattons att leastt one ttme per week tto observe ifl sttafl are flollowing diett orders and nott oflering consumers ittems tthey are known tto have an allergic reactton tto and make sure sttafl are oflering appropriatte substttttuttes as needed Responsible Partty Directt Supportt sttafl Home Manager, Program Directtor	10/16/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G495	A. BUILDING 00 B. WING	09/16/2011

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	Interview with HM #1 on 9/8/11 at 1:45 PM indicated client #4 was served oranges as part of his morning meal on 9/7/11. HM #1 indicated client #4 did have a food allergy to oranges and had the potential for an allergic reaction. HM #1 indicated client #4 is not able to identify the risks associated with consuming oranges. Interview with PD #1 on 9/8/11 at 1:54 PM indicated client #4 should not be offered food items that he is allergic to. 1.1-3-8(a)			
W9999	State Findings The following Community Residential Facilities for Persons with Developmental Disabilities rules were not met. 1. 431 IAC 1.1-3-1 Governing Body (b) The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by division. This state rule was not met as evidenced by: Based on record review and interview for 2 of 8 reportable incidents, the facility failed to report 2 incidents of missed medication doses for clients #7 and #8 within 24 hours. Findings include: The facility's incident reports, reportable incident reports and/or investigations were reviewed on 9/6/11 at 4:20 PM. The review indicated the following:	W9999	All directt care sttafl working att tthis home will receive rettraining on incidentt reporttng requirementts including whatt incidentts need tto be reportted designatted ttmeflrames in which incidentts are tto be reportted and tthe procedure flor immediattely nottflying tthe on call supervisor ofl reporttable incidentts The Home Manager will complette a tthorough review ofl consumers records including Daily Supportt records, Medical Administtratton Records, behavior ttracking and narrattve nottes a minimum of 3 ttmes per week flor 2 montths tto ensure tthatt all incidentts tthatt flall under tthe BDDS reporttable guidelines are reportted tto tthe Program Directtor witthin tthe designatted ttmeflrames Afler tthe 2 montth period tthe HM	10/16/2011

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	-BDDS report submitted on 3/7/11 indicated on 3/5/11, "It was reported by the oncall house manager that [client #7] did not receive his 9pm medications. The missed dosage consisted of lamictal 50 mg, depakote 500 mg and topamax 200 mg, these are all used for [client #7]' s seizure disorder." -BDDS report submitted on 8/3/11 indicated on 8/1/11 at 7:00 AM client #8 received 800 mg (milligrams) of tegretol (seizure medication) instead of 600 mg on 8/1/11. Interview with administrative staff #1 on 9/7/11 at 1:38 PM indicated all BDDS reportable incidents are supposed to be reported by staff within 24 hours of the incident. Administrative staff #1 indicated missed medication doses are considered BDDS reportable incidents. 1.1-3-1(b)		will complette a tthorough review ofl consumers records including Daily Supportt records, Medical Administtratton Records, behavior ttracking and narrattve nottes a minimum ofl 1ttme per week tto ensure tthatt all incidentts tthatt flall under tthe BDDS reporttable guidelines are reportted tto tthe Program Directtor witthin tthe designatted ttmeflrames For 2 montths tthe Program Directtor will complette a tthorough review ofl consumers records including Daily Supportt records, Medical Administtratton Records, behavior ttracking and narrattve nottes a minimum ofl 1ttme per week tto ensure tthatt all incidentts tthatt flall under tthe BDDS reporttable guidelines are reportted tto tthe Program Directtor witthin tthe designatted ttmeflrames The Program Directtor will receive rettraining on QMRP responsibilittes including ensuring tthatt documenttatton ofl BDDS reporttable incidentts are reportted tto tthe Administtrattor witthin designatted ttmeflrames and ensuring tthatt resultts ofl any needed investtgattons are being reportted tto tthe administtrattor witthin 5business days ofl tthe incidentt Ongoing tthe Area Directtor will review all BDDS reportts and investtgattons tto ensure tthatt incidentts are being reportted tto tthe administtrattor witthin designatted ttme	

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			flrames and tthatt needed investtgattons are reportted tto tthe administtrattor witthin 5 business days ofl tthe incidentt Responsible Partty: Home Manager, Program Directtor, Area Directtor, Qualitty Assurance Specialistt	